emailed Validation Letter 12/28/10

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 12-2-10
Amount $300.--
ck# 727972

I. IDENTIFICATION

Name: Western Baptist Transitional Care Unit

Address: 2501 Kentucky Avenue

City/County/Zip: Paducah, KY 42001

Telephone number: 270-575-2200; pbechtol@bhsi.com

Administrator: Polly Bechtold

Date facility operation began at current address: 11/21/1995

Date facility began operation under current owner: 11/21/1995

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	24	
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State	Profit	Individual
County	Nonprofit (X)	Partnership
City		Corporation (X)
Private (X)		

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Baptist Healthcare System

12/31

(OVER)

If facility owned or leased by a corporation, complete the following:

Name of corporation: Baptist Healthcare System

Address of corporation: 4007 Kresge Way, Louisville, KY 40207

President or Chairman: Rusty Purdy

Vice President: Jim Rickard

Secretary: Janet Norton

Treasurer: Carl Herde

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Holly Bechtold — Signature of authorized representative

VP of Nursing — Title:

11/23/10 — Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)